First Coast Family Medicine, PA

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Today's Date_____ **Soc Sec #**_____

Patient's Full Name_____

Address/City/Zip_____

_____

MAY WE LEAVE YOU A BRIEF MESSAGE AT ANY OF THE CONTACT NUMBERS BELOW? WHICH ONES?

Home Phone_____ **Cellular Phone**_____

Work Phone_____ **Sex**_____ **Birth Date**_____

Marital Status_____ **Occupation**_____

Employer_____

Employer Address/City/Zip_____

E-Mail_____

Spouse's/Parent's Name_____ **Birth Date**_____

Occupation_____ **Employer**_____

In case of emergency, call_____

Phone_____ **Relationship to you**_____

Who suggested you contact me?_____

May I contact him/her to acknowledge their kind recommendation? ☐YES ☐NO

Do you want this office to file insurance claims for you? ☐YES ☐NO
If Yes, please complete this section and allow us to make copies of your insurance cards.

Primary Insurance _____ **Policyholder**_____

Policy/ID #_____ **Group #**_____

Claims Address_____

_____

Secondary Insurance_____ **Policyholder**_____

Policy/ID #_____ **Group #**_____

Claims Address_____

_____

First Coast Family Medicine, PA

9191 RG Skinner Parkway Suite 603
Jacksonville, FL 32256
(904) 538-0950
(904) 538-0952 (fax)

AUTHORIZATION TO TREAT

I authorize the staff of First Coast Family Medicine, PA to provide me with medical treatment. I will inform the staff of First Coast Family Medicine, PA if I have any concerns about my healthcare.

I am the parent/legal guardian of _____. I authorize the staff of First Coast Family Medicine, PA to treat my son / daughter / legal ward named above.

PAYMENT AGREEMENT

I accept responsibility for payment of fees for services provided to myself and/or my dependent by First Coast Family Medicine, PA. I understand and agree that having health insurance coverage does not relieve me of full responsibility for all charges, even when the physician agrees to accept direct payment of benefits from the insurance and/or the plan management company. I understand that my insurance benefits may not pay for all charges incurred by myself or my dependent. I understand that this office has a no-show policy and I may be charged $25 for any appointments I miss that are not cancelled 24 hours in advance and agree to pay those charges. I further agree to pay all charges (such as collection agency commissions, attorney's fees, court costs, returned check charges) incurred by First Coast Family Medicine, PA, in the pursuit of payment for my delinquent account balance in addition to the full balance of my account. I also understand that interest charges may accrue on delinquent account balances and agree to pay such charges if my account becomes delinquent.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize First Coast Family Medicine, PA, to release to my insurance company and/or insurance plan management company information required for the purpose of pre-authorizing services and/or processing claims for reimbursement of services rendered by First Coast Family Medicine, PA. I also authorize First Coast Family Medicine, PA, to release the information necessary to secure full payment of my account through other parties, such as a collection agency or court of law, if my account becomes delinquent.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign and direct my insurance company and/or insurance plan management company to pay First Coast Family Medicine, PA, such amount as may be payable to me pursuant to the provisions of my contract.

I agree to promptly notify the staff of First Coast Family Medicine, PA of any changes in my personal information or insurance coverage.

Date_____ Signature_____

A copy of this form is as valid as the original.

FIRST COAST FAMILY MEDICINE, PA

Patient Name: _____ Date: _____

Date of Birth: _____ Social Security Number: _____

Acknowledgment of Receipt of Privacy Notice for First Coast Family Medicine, PA

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice.

_____

Signature of Patient or Legal Representative

Request for an *Exception* to the disclosure rules regarding the Release of Protected Health Information (PHI)

❑ Exception for Disclosure (Individuals or means where by P.H.I. may be released)

I authorize the following people to be involved in my care. This consent for disclosure includes both health and financial information.

Individual's Name (Please Print) *Relationship to Patient* *Phone Number(s)*

_____

_____

_____

Request for *Restriction* regarding the Release of Protected Health Information (PHI)

❑ Restriction for the disclosure of Protected Health Information (PHI)
(Individuals or means where by P.H.I. cannot be disclosed.) Please be specific in your request:

_____

_____

_____

_____ _____

Signature of Patient or Legal Representative Date of Request

For Practice Use Only:

_____ _____

Signature of Employee receiving request Date Received

Request for restriction/exception has been ❑ Approved ❑ Denied

Reason for denial: _____

_____ _____

Signature of Privacy Officer Date

First Coast Family Medicine, PA

Information for Your Physician

Name_____ **Date**_____

☐Referring or ☐Previous Physician_____ Phone_____

Allergies_____

What is the reason for your visit today? _____

_____

What other concerns would you like to discuss today?_____

_____

Vaccines (Include Year)
Tetanus _____
Other_____

Pneumonia _____
Hepatitis B _____
Other_____

Meningitis _____
Shingles_____
Other_____

Your Past Medical History – Please include how long you have had this condition

☐ADD/ADHD	☐COPD	☐Hepatitis	☐Sinus Problems
☐Allergies	☐Chronic Pain	☐High Blood Pressure	☐Sleep Difficulties
☐Anxiety	☐Depression	☐High/Low Blood Sugar	☐Stroke
☐Arthritis	☐Diabetes	☐Kidney Disease	☐Tuberculosis
☐Asthma	☐Emphysema	☐Liver Disease	☐Tobacco Use
☐Back Problems	☐Eye Problems	☐Lung Problems	☐Urinary Tract Infections
☐Brain Injury	☐Glaucoma	☐Menstrual Problems	
☐Breast Disease	☐Headaches	☐Premenstrual Syndrome	☐_____
☐Cancer	☐Heart Disease	☐PTSD	
☐Chemotherapy	☐Heart Attack	☐Radiation Therapy	☐_____

Your Surgical History

☐Appendectomy	☐Eye Surgery	☐Lung Surgery	☐_____
☐Back Surgery	☐Gall Bladder	☐Pacemaker	
☐Brain Surgery	☐Heart Surgery	☐Prostate Surgery	☐_____
☐Breast Surgery	☐Hernia Surgery	☐Skin Lesions	
☐C-section	☐Joint Surgery	☐Tonsillectomy	☐_____
☐Colon Surgery	☐Hysterectomy	☐Vasectomy	

When was your last: Dental Exam_____ Eye Exam_____ Colonoscopy_____

For Our Female Patients First Period_____ Last Period_____ Periods Are ☐Regular ☐Irregular ☐Menopausal	Last Pap Test_____ # Pregnancies_____ Are / Could you be pregnant now? Miscarriages/Abortions_____ # of Children_____	What form of birth control do you use? _____ Last Mammogram_____ Are you breastfeeding now?_____

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Family History (Please list who in your family is / was affected)

□Asthma_____	□Heart Disease_____
□Back Problems_____	□Hepatitis_____
□Brain Injury_____	□High Blood Pressure_____
□Cancer_____	□High Blood Sugar_____
Type of Cancer_____	□Kidney Disease _____
□Chemotherapy_____	□Liver Disease_____
□COPD_____	□Lung Problems_____
□Depression_____	□Menstrual Problems_____
□Diabetes _____	□Mental Illness_____
□Emphysema_____	□Stroke_____
□Eye Problems_____	□Substance Abuse_____
□Glaucoma_____	□Tuberculosis_____
□Heart Attack_____	□_____

Social History

Do you have a Living Will or Advanced Directive? □ Yes □ No Religious Preference_____

Race or Nationality of Parents_____ **What is your primary language?**_____

What type of work do you do?_____

How often do you exercise? ☐ Frequently ☐ Infrequently ☐ Sedentary Type of exercise?_____

Tobacco

☐ Never ☐ Quit ☐ Smoke/Dip _____ packs/day

Alcohol

☐ Never ☐ Quit ☐ Drink _____ alcoholic beverages/day

_____ alcoholic beverages/week

Current Medications – Include Prescriptions, Vitamins and Over the Counter Items

Name of Medicine	Strength	How often do you take it	Who prescribed it

Pharmacy: ☐Costco ☐CVS ☐Ossi's ☐Publix ☐Sam's ☐Target ☐Walgreen's ☐Walmart ☐Winn-Dixie ☐Other_____

What Street/Road is it on? _____